Complete Summary

GUIDELINE TITLE

Missed hormonal contraceptives: new recommendations.

BIBLIOGRAPHIC SOURCE(S)

Guilbert E, Black A, Dunn S, Senikas V, Berube J, Charbonneau L, Guilbert E, Leboeuf M, McConnery C, Gilbert A, Risi C, Roy G, Steben M, Wagner MS, Aggarwal A, Burnett M, Davis VJ, Fisher WA, Lamont JA, Levinsky E, MacKinnon K, McLeod NL, Pellizzari R, Wells T. Missed hormonal contraceptives: new recommendations. J Obstet Gynaecol Can 2008 Nov;30(11):1050-62, 1063-77. [92 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

- Unintended pregnancy
- Missed hormonal contraception

GUIDELINE CATEGORY

Counseling
Management
Prevention
Risk Assessment

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Obstetrics and Gynecology

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Nurses
Patients
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

To provide evidence-based guidance for women and their health care providers on the management of missed or delayed hormonal contraceptive doses in order to prevent unintended pregnancy

TARGET POPULATION

Women of childbearing age

INTERVENTIONS AND PRACTICES CONSIDERED

1. Provision of written and oral instructions regarding missed contraceptive pill doses
2. Provision of telephone/electronic resources regarding missed contraceptive pill doses
3. Assessment of hormone free interval
4. Back up contraception
5. Emergency contraception
6. Counseling on alternative methods of contraception

MAJOR OUTCOMES CONSIDERED

- Unintended pregnancy
- Incidence of missed contraceptive pill doses

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Medline, PubMed, and the Cochrane Database were searched for articles published in English, from 1974 to 2007, about hormonal contraceptive methods that are available in Canada and that may be missed or delayed. Relevant publications and position papers from appropriate reproductive health and family planning organizations were also reviewed. The quality of evidence is rated using the criteria developed by the Canadian Task Force on Preventive Health Care.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Quality of Evidence Assessment*

I: Evidence obtained from at least one properly randomized controlled trial.

II-1: Evidence from well-designed controlled trials without randomization.

II-2: Evidence from well-designed cohort (prospective or retrospective) or case-control studies, preferably from more than one centre or research group.

II-3: Evidence obtained from comparisons between times or places with or without the intervention. Dramatic results from uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be included in this category.

III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

*Adapted from the Evaluation of Evidence criteria described in the Canadian Task Force on Preventive Health Care.

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Classification of Recommendations*

A. There is good evidence to recommend the clinical preventive action

B. There is fair evidence to recommend the clinical preventive action

C. The existing evidence is conflicting and does not allow to make a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making

D. There is fair evidence to recommend against the clinical preventive action

E. There is good evidence to recommend against the clinical preventive action

L. There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making

*Adapted from the Classification of Recommendations criteria described in the Canadian Task Force on Preventive Health Care.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

This committee opinion has been reviewed by the Social and Sexual Issues Committee and reviewed and approved by the Executive of the Society of Obstetricians and Gynaecologists of Canada.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The grades of recommendations (A-E and L) and levels of evidence (I, II-1, II-2, II-3, and III) are defined at the end of the "Major Recommendations" field.

Summary Statements

1. Instructions for what women should do when they miss hormonal contraception have been complex and women do not understand them correctly. **(I)**
2. The highest risk of ovulation occurs when the hormone-free interval is prolonged for more than seven days, either by delaying the start of combined hormonal contraceptives or by missing active hormone doses during the first or third weeks of combined oral contraceptives. **(II)**
3. Ovulation rarely occurs after seven consecutive days of combined oral contraceptive use. **(II)**

Recommendations

1. Health care providers should give clear, simple instructions, both written and oral, on missed hormonal contraceptive pills as part of contraceptive counselling. **(III-A)**
2. Health care providers should provide women with telephone/electronic resources for reference in the event of missed or delayed hormonal contraceptives. **(III-A)**
3. In order to avoid an increased risk of unintended pregnancy, the hormone-free interval should not exceed seven days in combined hormonal contraceptive users. **(II-A)**
4. Back-up contraception should be used after one missed dose in the first week of hormones until seven consecutive days of correct hormone use are established. In the case of missed combined hormonal contraceptives in the second or third week of hormones, the hormone-free interval should be eliminated for that cycle. **(III-A)**
5. Emergency contraception and back-up contraception may be required in some instances of missed hormonal contraceptives, in particular when the hormone-free interval has been extended for more than seven days. **(III-A)**
6. Back-up contraception should be used when three or more consecutive doses/days of combined hormonal contraceptives are missed in the second and third week until seven consecutive days of correct hormone use are established. For practical reasons, the scheduled hormone-free interval should be eliminated in these cases. **(II-A)**
7. Emergency contraception is rarely indicated for missed combined hormonal contraceptives in the second or third week of the cycle unless there are repeated omissions or failure to institute back-up contraception after the missed doses. In cases of repeated omissions of combined hormonal contraceptives, emergency contraception may be required, and back-up contraception should be used. Health care professionals should counsel women in these situations on alternative methods of contraception that do not demand such stringent compliance. **(III-A)**

See the original guideline document for:

- Figure 1. Missed combined oral contraceptives
- Figure 2. Missed contraceptive patch
- Figure 3. Missed contraceptive ring
- Figure 4. Missed progestin only pills
- Figure 5. Missed contraceptive injection

Definitions

Studies were reviewed and evaluated for quality according to the method outlined by the Canadian Task Force on Preventive Health Care:

Quality of Evidence Assessment*

I: Evidence obtained from at least one properly randomized controlled trial.

II-1: Evidence from well-designed controlled trials without randomization.

II-2: Evidence from well-designed cohort (prospective or retrospective) or case-control studies, preferably from more than one centre or research group.

II-3: Evidence obtained from comparisons between times or places with or without the intervention. Dramatic results from uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be included in this category.

III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

Classification of Recommendations**

A. There is good evidence to recommend the clinical preventive action

B. There is fair evidence to recommend the clinical preventive action

C. The existing evidence is conflicting and does not allow to make a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making

D. There is fair evidence to recommend against the clinical preventive action

E. There is good evidence to recommend against the clinical preventive action

L. There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making

*The quality of evidence reported in these guidelines has been adapted from the Evaluation of Evidence criteria described in the Canadian Task Force on the Periodic Health Exam.

**Recommendations included in these guidelines have been adapted from the Classification of Recommendations criteria described in the Canadian Task Force on Preventive Health Care.

CLINICAL ALGORITHM(S)

Clinical algorithms are provided in the original guideline document for:

- Missed combined oral contraceptives
- Missed contraceptive patch
- Missed contraceptive ring
- Missed progestin only pills

- Missed contraceptive injection

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Health care providers will be able to offer clear information to women who have not been adherent in using hormonal contraception with the purpose of preventing unintended pregnancy.

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed. Local institutions can dictate amendments to these opinions. They should be well documented if modified at the local level. None of these contents may be reproduced in any form without prior written permission of the Society of Obstetricians and Gynaecologists of Canada (SOGC).

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Clinical Algorithm

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Guilbert E, Black A, Dunn S, Senikas V, Berube J, Charbonneau L, Guilbert E, Leboeuf M, McConnery C, Gilbert A, Risi C, Roy G, Steben M, Wagner MS, Aggarwal A, Burnett M, Davis VJ, Fisher WA, Lamont JA, Levinsky E, MacKinnon K, McLeod NL, Pellizzari R, Wells T. Missed hormonal contraceptives: new recommendations. J Obstet Gynaecol Can 2008 Nov;30(11):1050-62, 1063-77. [92 references] PubMed

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2008 Nov

GUIDELINE DEVELOPER(S)

Society of Obstetricians and Gynaecologists of Canada - Medical Specialty Society

SOURCE(S) OF FUNDING

Society of Obstetricians and Gynaecologists of Canada

GUIDELINE COMMITTEE

Social and Sexual Issues Committee

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Disclosure statements have been received from all members of the committee.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the Society of Obstetricians and Gynaecologists of Canada Web site.

Print copies: Available from the Society of Obstetricians and Gynaecologists of Canada, La société des obstétriciens et gynécologues du Canada (SOGC) 780 promenade Echo Drive Ottawa, ON K1S 5R7 (Canada); Phone: 1-800-561-2416

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI Institute on April 30, 2009. The information was verified by the guideline developer on May 22, 2009.

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